STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

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TO: All County Welfare Directors Letter No. 79-28

CALIFORNIA'S MEDI-CAL QUALITY CONTROL/CORRECTIVE ACTION REPORT FOR APRIL-SEPTEMBER 1978

Attached is a copy of California's latest Medi-Cal Quality Control/Corrective Action (MQC/CA) Report to the U. S. Department of Health, Education, and Welfare for the eligibility period/service period July-September 1978.

This report is concerned only with beneficiaries whose costs are shared by the Federal Government under the Medicaid program of the Social Security Act; hence, the use of the term "Medicaid" rather than "Medi-Cal" in the report. This means that an assessment of Medi-Cal's state-only program for medically indigent adults is not contained in this report.

Key Points in Interpreting Report

As a result of new federal guidelines, there are a number of major changes from previous MQC/CA reports, which must be kept in mind when interpreting this report.

The report assesses the accuracy of Medi-Cal's performance in three functions:

1. Eligibility and share-of-cost determinations
2. Processing of provider fee-for-service claims
3. Identification of "third-party liability" -- beneficiary private health insurance or other non-Medi-Cal health coverage

Before, only the first function was assessed.

The report assesses performance for all three major federal Medi-Cal beneficiary groups:

1. Aid to Families with Dependent Children (AFDC) recipients
2. Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipients
3. Medically Needy Only persons/Medically Indigent (MNO/MI) children

Before, only the third group was assessed.

The report emphasizes the actual dollar impact of any errors found, more than previous reports. It reflects an improved federally defined method of calculating that dollar impact and projecting it to the statewide Medicaid program. It also reflects federal plans to impose fiscal sanctions on states whose "percent of Medicaid dollars spent in error" is higher than the upcoming national standard.

As in previous reports, errors are also described in this report in terms of frequency of occurrence. This perspective continues to be an important gauge of government effectiveness in managing and operating the Medi-Cal program, since it reflects how well the potential for misspent dollars is being controlled.

HIGHLIGHTS OF FINDINGS, CALIFORNIA MEDICAID-ONLY ELIGIBILITY

For the July-September 1978 performance period, the following two charts depict the Medicaid-only frequency of eligibility errors, and dollar impact of those errors respectively, when the Medicaid-only program is viewed as an independent, self-contained program. In these charts, the Medicaid-only cases with eligibility errors have been compared only to the 417 Medicaid-only cases in the July-September 1978 quality control sample.

Erroneous Medicaid Payments Due to Eligibility Errors in Medicaid-Only Cases (Base: Medicaid-Only Patient Costs)	MAO
A. Error payments for ineligible recipients	2.11%
B. Error payments resulting from case liability understated errors	0.95%

Frequency of Medicaid-Only Eligibility Errors (Base: Medicaid-Only Total Population)	
A. Cases having one or more errors	22.54%
B. Ineligible cases	4.80%
C. Eligible with ineligible members	0.96%
D. Liability understated error only	11.03%
E. Liability overstated error only	1.68%
F. Liability overstated error with ineligible members	0.24%

The majority of errors were agency-caused as opposed to client-caused. In Table II A in the Appendix of the report, the dollar amount of agency errors is shown to be greater than the beneficiary errors. The agency errors fell principally in two areas: "correct policy but incorrectly applied" and "failure to take indicated action". These two areas accounted for 90.41 percent of the dollar impact of all Medi-Cal-only liability/eligibility errors. In contrast, beneficiary errors were centered in one area, Change in Beneficiary Circumstances Not Reported, which accounted for only 7.36 percent of the total Medicaid-only liability/eligibility dollar errors.

The major Medicaid-only eligibility dollar errors found in this reporting period fell into four categories: deprivation, real property, other personal property, and earned income.

The following table shows the relative dollar impact of each category of Medicaid-only eligibility:

Element	Percent	Projected Statewide Dollar Impact
Deprivation	18.30%	$ 5,057,149
Real Property	17.97%	4,966,842
Other Personal Property	18.96%	5,237,761
Earned Income	15.36%	4,244,393

These 4 categories accounted for only 30 percent of all Medicaid-only eligibility errors; but conversely, 71 percent of the dollar impact of those errors.

Based on the July-September 1978 sample period, Medicaid-only eligibility errors have a total projected annual cost of $27.7 million. This means there is still significant potential for program savings through further reduction of these errors. We will continue to work toward that reduction at the state level and we appreciate your continued efforts in reducing Medicaid-only errors on an individual county basis. We look forward to working with you in this process.

I wish also to express my particular appreciation for your past efforts, which have helped produce the low statewide Medicaid-only eligibility error rate reflected in this reporting period. As you know, this period will be used to determine the national Medicaid eligibility error rate standard. This standard will be used in determining possible future federal fiscal sanctions in the Medicaid program.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Field Representatives